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Challenges to Healthcare Reform in Crisis-Hit Greece

Desafios à reforma dos cuidados de saúde na Grécia afetada pela crise

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CHALLENGES TO HEALTHCARE REFORM IN CRISIS-HIT GREECE

Abstract: This paper critically examines the health reform trajectory in Greece in the last decade. The first part provides an overview of the Greek healthcare system shortly before the crisis, with an emphasis on the incomplete development of a national health system beset by inequalities in coverage and funding. At the backdrop of the crippling debt-crisis that engulfed the country in the late 2000s, the second part of the study tracks the major healthcare reforms under the successive bailout packages. These are examined from the point of view of whether they can secure the public system's long-term viability and promote equity, or if they contribute to its withering away instead. The third part of the article looks at the impact of the austerity-driven reforms on inequalities in healthcare, highlighting some major findings regarding health outcomes.

Keywords: austerity, health funds, inequalities in healthcare, national health system, out-of-pocket payments.

DESAFIOS À REFORMA DOS CUIDADOS DE SAÚDE NA GRÉCIA AFETADA PELA CRISE

Resumo: Este artigo analisa criticamente a trajetória da reforma da saúde na Grécia na última década. A primeira parte apresenta uma visão geral do sistema de saúde grego em vésperas da crise, com ênfase no desenvolvimento incompleto de um sistema nacional de saúde marcado por desigualdades na cobertura e no financiamento. No contexto da debilitante crise de endividamento em que o país mergulhou, no final da década de 2000, a segunda parte do estudo acompanha as principais reformas dos serviços de saúde sob os sucessivos programas de resgate. Estes são examinados da perspetiva da sua eventual capacidade de garantia de viabilidade do sistema público a longo prazo, questionando ainda se promovem a equidade, ou se, em vez disso, contribuem para o seu desaparecimento. Na terceira parte do artigo, analisa-se o impacto das reformas orientadas pela austeridade sobre as desigualdades nos cuidados de saúde e destaca-se algumas das principais conclusões sobre os resultados em matéria de saúde.

Palavras-chave: austeridade, desigualdades nos cuidados de saúde, fundos de saúde, pagamentos do próprio bolso, sistema nacional de saúde.

1. INTRODUCTION

Greece has suffered the most severe consequences of the crisis that followed the global financial meltdown of 2008. The country went through an eight-year program of external financial assistance by the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF), the so-called Troika, in exchange for strict austerity measures and structural adjustment across a large spectrum of policy areas. A moderate economic recovery in 2017 and 2018, accompanied by a limited fall in the unemployment rate (from 25% in 2015 to about 19% in late 2018), is a positive development. Yet the economy is still in dire straits. Sovereign debt amounts to around 180%of Gross Domestic Product (GDP) – the highest in the European Union (EU) – and it remains 25% lower than its pre-crisis peak.[1] Moreover, post-bailout commitments for exorbitant fiscal primary surpluses in the years ahead will deprive the economy of serious resources in the road to recovery. On August 20, 2018 Greece formally exited its bailout program. Yet as the country is highly indebted to the European official sector (close to €260 billion), "enhanced" surveillance by the international lenders will continue (IMF, 2018; EC, 2018a). Compared to the other Euro area countries that went through a financial bailout, in Greece post-program surveillance will be of higher frequency (on a quarterly basis) and the monitoring of specific policies stricter.[2]

For a long time, the Greek healthcare system was stuck halfway between a highly fragmented social health insurance and a national health service model. In the early 1980s a universalist national health system ESY (Ethniko Sistima Ygeias) was introduced. However, until lately, the ESY hardly reached the state of a fully-fledged national health service. Both in terms of funding and service delivery a mixed system continued to operate: an occupation-based health insurance system combined with a national health service, but private provision was expanding too (mostly out-of-pocket payments as private health insurance remained negligible). The economic and financial crisis that engulfed the country as well as strong outside pressure by the international lenders brought reform, along the lines of the "path shift" introduced in 1983, high on the agenda. This precipitated changes, such as the unification of health funds, the standardization of contributions and the equalization of the benefits package across socio-occupational groups. Yet, at the same time, rising user charges, rolling back of

[1] This is a dismal performance compared to the other South European countries, which were badly hit by the crisis too. In Portugal GDP (in real terms) reached its 2008 level in 2018, and in Spain it even surpassed its pre-crisis level (Romei, 2018).

[2] This indeed is "no true exit", and "Greece's parliament will have limited economic decision-making authority for years, or perhaps decades" (Mody, 2018).

public provision, and rationing through increasing waiting times and other blockage mechanisms have a negative impact on access, equity and service quality.

We start our analysis by briefly laying out an explanatory framework for the "incomplete reform" until the eruption of the crisis and the window of opportunity that has emerged since then for pursuing system rationalization and consolidation. Then, we critically discuss the major reforms that took place over the last decade. These are examined along two core dimensions of health systems: a) the funding and allocation of financial resources to providers, and (b) the structure and governance of provision. A major question addressed is whether the ongoing reforms can enhance and sustain universalism, or instead do they contribute to the withering away of a public system, which, anyway, never in the past embraced strong universalistic principles. Corroborating evidence of a bleak future is manifested by data on increasing inequalities in healthcare regarding accessibility to and affordability of health services.

2. The Crisis as Catalyst: An Analytical Context

Two analytical accounts of policy reform are illuminating for understanding: a) why the path shift towards a national health system has for a long-time remained a half way reform in Greece, and b) which dynamic underlies the attempts to complete the reform in the last few years, though amidst severe fiscal retrenchment. These consist in Thelen's conceptualization of "institutional layering" (2004), and Kingdon's analysis of "windows of opportunity" for policy breakthroughs (1995).[3]

As extensively shown in the social policy literature, institutional arrangements are characterized by a considerable "stickiness". They consolidate interests and commitments that create "veto" points, which highly increase the political (and often also the economic) cost of change (see Pierson, 1996; also Wilsford, 1994 on "Path dependency"). Critical junctures due to economic and/or political crises provide windows of opportunity for major reforms. However, for this to happen there needs to be an alignment favorable to change between three components: actors, institutions and ideas. Namely, there needs to be problem recognition by actors, willingness/ability to act and availability of policy ideas (Kingdon, 1995). Furthermore, as Thelen (2004: 35) has shown, incremental change, particularly in the form of "institutional layering" (that is, adding a new "layer" on an otherwise stable institutional setting) can be a driver of transformation too, particularly in the long run. Under certain conditions, if this "layering" process takes place in a prolonged period it can "significantly alter the overall trajectory of an institution's development" (*ibidem*).

[3] For a detailed analysis of the political and policy dynamics in Greece, at various stages of the evolution of the healthcare system since the restoration of democracy in the mid-1970s, see Petmesidou (forthcoming).

In the realm of health politics and policy, in Greece, three reform efforts are of crucial importance: a) the introduction of ESY in the early 1980s; b) a failed attempt to revive reform momentum for completing the shift towards a national health system in the early 2000s; and c) a crisis-driven reform under the bailout program.

A few years after the restoration of democracy in the country, the introduction of a national health system took place at a critical juncture consisting in the rise to power, for the first time, of a socialist party (the Panhellenic Socialist Movement Party – PASOK), in 1981. The way the reform fared reveals the obstacles to wholesale change. As shown elsewhere (Petmesidou, forthcoming):

> Path-dependent institutional factors hindered the government's willingness/ability to pursue the breakthrough initiated by Law 1397 of 1983 that established ESY. PASOK consolidated its dominant position in the Greek political system by effectively rebuilding/expanding clientelist relations, a condition that hardly allowed even a minimum consensus among social actors about how to articulate redistributive issues along the lines of universalist citizenship values and criteria.

Hence, a watered-down version of the reform was implemented. This was a politically expedient solution as the government was confronted by strong veto points within the medical profession and the privileged health insurance funds (mostly sickness funds of employees in public banks, telecommunications and other public enterprises).

Major stipulations in the law, such as uniform funding and service provision for all citizens, the gradual absorption of the private by the public sector, and a more balanced regional distribution of health infrastructure and personnel remained largely on paper, and the reform did not significantly change the status quo in health insurance. Universal access was limited to hospital care. Primary care was neglected, largely provided by the private sector, the health centers of IKA (the Social Insurance Organization for the majority of private sector employees), as well as by medical practitioners contracted by various sickness funds. Private spending continued to rise, and many privileged health insurance funds maintained their prerogatives. Thus, quite soon after the proclamation of a radical reform, social policy returned to its old patterns. Following Thelen (2004), we would argue that the reform added "a new 'layer' (universalist healthcare) onto an existing stable institutional framework (a splintered health insurance system)" (Petmesidou, forthcoming). In the context of a political dynamics heavily relying on statist/clientelist practices, instead of this process triggering a momentum of policy breakthrough over time, it sustained a "disjointed

pattern" with low degree of institutional coherence and prevalent path-dependent features, over the following two decades (*ibidem*). Diversity of coverage, multiplicity of funding and system fragmentation persisted and accounted for lack of coordination of purchasing policies, soaring ESY deficits, alarmingly rising pharmaceutical expenditure and other system predicaments. At the turn of the century, an initiative by the Ministry of Health, under the then PASOK government, to tackle fragmentation, rationalize and de-concenter decision-making and control, and regulate relations between key health actors met strong opposition from various quarters, even within the government. This caused the resignation of the Minister of Health and the downsizing of reform ambitions.

The deep economic and financial crisis significantly reshuffled political relationships. Strong outside pressure by the country's international lenders made it imperative for the government to push through reforms, in tandem with harsh cuts in funding and receding public provision. Under the bailout program a (more or less forced) alignment between the three spheres mentioned above – institutions, actors and ideas – has occurred. This created a window of opportunity that made long-overdue reforms possible (Petmesidou, forthcoming). Amidst a severe economic and financial crisis, the resources for clientelist exchanges significantly diminished, the legitimacy of political parties, trade unions and other major political actors waned, and the party system exhibited a deep systemic crisis (Petmesidou, 2017: 157). Moreover, the bailout deal imposed an upward shift in decision-making for major reforms to the international lenders (and mainly to the crisis-management apparatus of the EU). The role of the executive was strengthened, while the ability of trade unions, associations, and other "veto" groups to sway political decisions significantly weakened (Petmesidou and Glatzer, 2015: 170-176). Moreover, the bailout conditions allowed the government to shift the blame of reform and austerity to the Troika, in order to shield itself from political risk. Importantly, a pool of policy measures and regulatory instruments (among others, e-prescribing, diagnosis protocols, closed-budgets of health units, etc.) provided the constitutive elements of the reform. These were advocated by the EC, the IMF and the World Health Organization (WHO), which played a crucial role in guiding policy. The combination of the above factors facilitated a coupling of the three major streams in policy. Namely, under the sovereign debt crisis, the shift in the power and decision-making dynamics forced political actors to recognize the system's functional deficits, made imperative for them to act, and set the policy options.

3. THE REFORM TRAJECTORY

3.1. TRENDS IN HEALTH EXPENDITURE – MAIN DIMENSIONS OF REFORM

Soaring deficits by public hospitals and rapidly increasing pharmaceutical expenditure over the 2000s greatly strained the state budget. In the decade prior to the eruption of the crisis, per capita total health expenditure (measured in constant Purchasing Power Parities, PPPs) grew on average annually by about 6.6% (EU15 average: 3.6%; Petmesidou, forthcoming). Markedly, average yearly per capita private spending rose faster than public spending (by 7.7 and 5.8% respectively). Especially high was the rate of growth of per capita pharmaceutical spending: 11.1% yearly on average (in constant PPPs) during the 2000s (average for the other three South European countries: 1.3%; *ibidem*).[4] Nevertheless, in 2009, per capita public health expenditure (in constant PPPs) was about a third lower of the EU15 average. Yet private spending exceeded the corresponding rates for the EU15 and the other three South European countries (Table I).

Deep spending cuts took central stage in Greece's Economic Adjustment Program (EAP) under the successive bailout packages. So did also some key issues, which have been debated since the inception of ESY in 1983, but never materialized, such as devolution, integration of primary and secondary care, reduction of fragmentation in health insurance, etc. The changing demographic makeup is also a matter of concern as Greece is set to experience rapid ageing in the coming decades: the share of the population aged over 65 years from about 20% in 2015 is estimated to reach 35% in 2060 (among the highest rates in the EU; EC, 2018b: 191). Together with fast medical technology advancement and rising expectations for quality provisions and choice, population ageing will increase pressure on public spending (particularly on chronic diseases and geriatric and personal care).[5]

Strict ceilings were set in the EAP for total public health financing and its constitutive schemes – for instance, total public health spending is capped at (or below) 6% of GDP and pharmaceutical expenditure at about 1% of GDP, which however has shrunk by a quarter since 2010, as mentioned above. From 2009 to 2017 total health spending (in current prices) dropped from €22.5 billion to €14.9 billion and public spending (government and compulsory social health insurance) almost halved (from €15.4 to €9.1 billion).[6] This is a rather steep contraction compared to the other three

[4] In 2009, outpatient pharmaceutical expenditure amounted to roughly about 40% of total public health spending.

[5] According to the latest data by the Hellenic Statistical Authority (ELSTAT), in 2014, about 50% of the population suffered from a chronic disease. Accessed on 20.08.2018, at http://www.statistics.gr/en/statistics/-/publication/SHE22/-.

[6] OECD health database. Accessed on 15.09.2018, at https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

South European countries, which have also implemented austerity programs (for instance in Portugal, in 2017 public health spending in current prices was only about 6% lower than its peak rate in 2009).

TABLE I – Health Indicators

	Per capita expenditure (constant PPPs, OECD base year*)									
	2009-2013					**2017**				
	Greece	***Portugal***	***Spain***	***Italy***	***EU15***	***Greece***	***Portugal***	***Spain***	***Italy***	***EU15***
Total health expenditure	2826/ 1960	2651/ 2340	2885/ 2722	3103/ 2965	3860/ 3936	2015	2515	2981	3033	4084
Public health expenditure	1937/ 1218	1854/ 1566	2175/ 1933	2430/ 2255	3055/ 3054	1233	1676	2110	2245	3186
Private health expenditure	889/ 726	798/ 774	710/ 789	673/ 710	804/ 881	781	839	871	788	899
Total expenditure on medical goods**	834/ 567	635/ 461	639/ 620	588/ 588	686*** /623	625	474	674	625	642
Public expenditure on medical goods**	648/ 337	351/ 229	306/ 229	313/ 322	436*** /370	367	231	324	353	391
	Average yearly change of per capita expenditure (constant PPPs, OECD base year*)									
	2009-2013					**2013-2017**				
	Greece	***Portugal***	***Spain***	***Italy***	***EU15***	***Greece***	***Portugal***	***Spain***	***Italy***	***EU15***
Total health expenditure	-8.7	-3.1	-1.4	-1.1	0.5	0.7	1.8	2.3	0.6	1.7
Public health expenditure	-11.0	-4.1	-2.9	-1.8	0.0	0.3	1.7	2.2	-0.1	1.1
Private health expenditure	-4.9	-0.7	2.7	1.3	2.1	1.9	2.0	2.5	2.6	0.5
Total expenditure on medical goods**	-9.3	-7.7	-0.8	0.0	-	3.3	0.9	2.8	1.6	1.0
Public expenditure on medical goods**	-15.1	-10.2	-6.3	0.7	-	2.9	0.3	1.2	2.4	1.8

Notes: *Constant prices (2010), constant PPPs (2010), in US dollars.
** Mostly pharmaceuticals (for Greece, Portugal, Spain and EU15 most recent data for expenditure on medical goods refer to 2016).
*** EU average in 2009 excludes Ireland and the UK due to missing data.

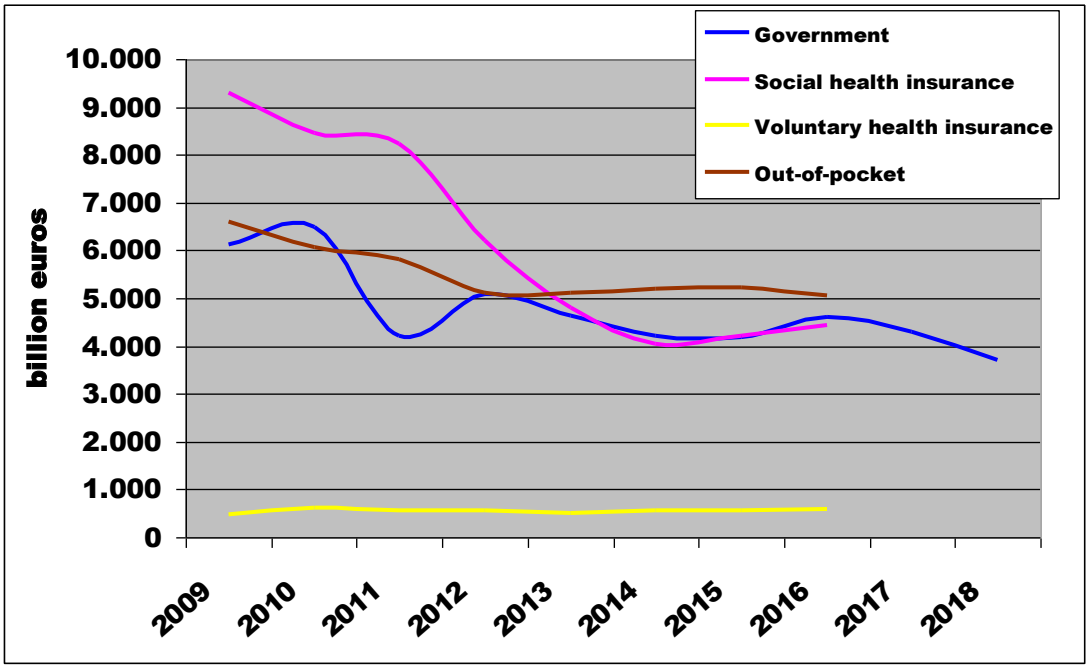
Source: OECD Health Data and own elaboration. Accessed on 30.10.2018, at https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Between 2009 and 2013, per capital public health spending, in real terms, contracted by 11% on average annually, and stagnated afterwards. Thus, in 2017 per

capita total health spending dropped to about half that of the EU15, and per capita public expenditure to a third of the respective EU15 average (Table I). Equally sharp has been the decline of per capita public spending on medical goods (mostly pharmaceuticals, in PPPs and constant prices).

Private spending (out-of-pocket – including informal – payments and private health insurance premiums, the latter of limited importance though) stood at €7.1 billion in 2009 (Figure I). It decreased until 2012, but it then resumed a slight upward trend, despite falling household incomes until recently. In 2016, private spending amounted to about 40% of total health spending, compared to about 30% in the other three South European countries, and to 24% in EU15 (Figure II). Taking also into account the persistently low degree of satisfaction with public health services (Petmesidou *et al*., 2014: 333-335; Eurofound, 2017: 54-56), extensive reliance on private spending highly questions whether a truly universal system has ever been in place in Greece.

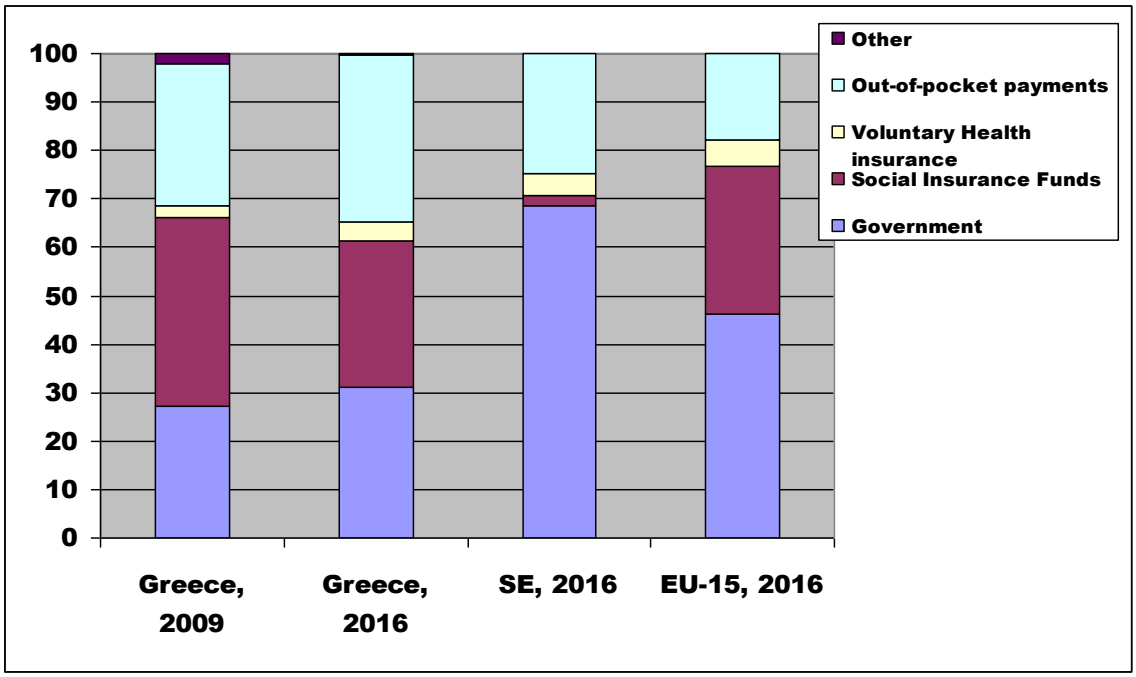
FIGURE I – Health Care by Financing Scheme (2009-2016, Current Prices)



Note: The amount of government financing for 2018 is taken from the State budget.

Source: ELSTAT health data. Accessed on 30.10.2018, at http://www.statistics.gr/en/statistics/-/publication/SHE35/-.

FIGURE II – Percentage Constitution of Health Care Financing



Note: SE = average for Spain, Italy and Portugal.

Source: Petmesidou, forthcoming.

The crisis intensified financial, organizational and equity problems that characterized healthcare in the country for several decades. Most importantly, great diversity in the range and quality of provisions among the plethora of sickness funds kept inequality high.[7] Since 2011, in the context of the reform dynamics briefly highlighted above, a number of measures have been introduced, apparently in order to tackle major system deficiencies. However, a controversial trend is clearly manifest. Steps are taken towards the completion of the transition to ESY and system rationalization. But large-scale public health spending cutbacks and a range of policy options are shifting the cost away from the State and impose significant barriers of access to and use of care. Strikingly, at the level of rhetoric, the framing of the reform stresses the need for deep cuts as a way to keep the publicly operated system afloat, yet a shift towards a "universalism" of basic provision looms large (Petmesidou *et al.*, 2014: 345).

[7] As Petmesidou and Guillén stated (2008: 115): "in 2006 health care expenditure (including health care services and benefits) per head of the insured in the social fund for the self-employed (OAEE [the Social Insurance Fund for Self-employed Workers], excluding the professions) amounted to 344 euros. The corresponding rates for IKA, OGA (Agricultural Insurance Organization) and some of the 'noble funds' for public utility employees, like those in telecommunications and electricity, were 635, 648, 1,040 and 980 euros respectively".

On the funding side, a major structural reform consists in the separation of the health from the pension branches of social insurance funds and the merging of the former into a unitary organization (the National Health Services Organization, Greek acronym EOPYY, legislated in 2011), to act as a single purchaser of health services. This was accompanied by the equalization of contributions and the standardization of the health benefits basket across occupational groups. Also, mechanisms of monitoring and control of services were put in place, facilitating a tighter spending oversight. Changes in the allocation arrangements, by which funding is transferred to services providers, were also implemented, particularly regarding hospital payment systems.

On the organizational/governance side, consolidating hospitals into larger units, re-configuring cost-accounting and management, as well as integrating primary and secondary care have been varyingly implemented so far. Of significant importance is a three-year plan to overhaul primary care, which started being rolled out in 2018. The aim is to create a gate-keeping system with the establishment of first contact, decentralized local health units, which will guide patients, through referral procedures, to the second tier of ambulatory care and to inpatient care.

The Greek health system has persistently been highly centralized. Despite the establishment of Regional Health Authorities (YPEs in the Greek acronym) in the early 2000s, plans to devolve responsibility for the operation and management of health units failed to materialize. Recent reforms disclose a two-way trend: The pooling of health insurance contributions through the creation of EOPYY indicates a move towards centralization, while the assignment of control over primary care to YPEs points in the direction of decentralization. However, it remains to be seen whether the latter move will be backed by the devolution of real decision-making power.

3.2. Funding Side Changes: How Healthcare Revenue Is Raised and Allocated to Service Producers

Health financing derives from three sources: taxation – over 50% of it being indirect taxes in 2017 (Independent Authority for Public Revenue, 2017: 2 and 6) –, social insurance contributions and private, mostly out-of-pocket, spending. Between 2009 and 2016, we observe a significant change in the composition of healthcare financing with the sharp drop of the health funds' share from about 40 to 29% and the increase of out-of-pocket payments to over a third (Figure II above). Rising unemployment and inability to pay contributions by a significant number of self-employed and small businesses account for the decline of health insurance revenues. Moreover, extensive reliance on out-of-pocket payments and indirect taxation renders the system highly regressive.

From 2011 to 2016, the amalgamated pension branches of social insurance funds were responsible for collecting contributions, which then were transferred to EOPYY. In 2017, this function was undertaken by a new body (the Unified Body of Social Insurance, Greek acronym EFKA,) responsible for the collection of health and pension insurance contributions. EOPYY should maintain a balanced budget, as state subsidy is henceforth confined to the organization's operational costs (around 0.4% of GDP; Economou *et al*., 2017: 56; see also Karakolias and Polyzos, 2014).[8]

While the health insurance funds were under the jurisdiction of the Ministry of Labour, Social Insurance and Welfare, EOPYY came under the authority of the Ministry of Health. Initially the organization was also responsible for the management of primary care (the healthcare centers previously belonging to the health insurance funds). But in 2014, a split took place between insurance-purchasing functions retained by EOPYY, and primary and ambulatory care provision undertaken by a new organization, the National Primary Healthcare Network (PEDY, the Greek acronym). Potentially, as the single purchaser of publicly provided healthcare services, EOPYY could weigh heavily on bargaining with suppliers. But its powers are greatly limited as decisions rest with the Ministry of Health in a context of highly centralized collective bargaining with suppliers' associations.[9]

The State budget covers the salaries of health and administrative personnel in public hospitals, primary/ambulatory care in local health units, health centers and outpatient departments, and capital investment. It also provides subsidies to public hospitals and EOPYY, as mentioned above. Services offered by public hospitals are paid by EOPYY, until 2013 on a fixed per person, per diem basis, and since then on the basis of diagnostic related groups (DRGs). EOPYY also funds service provision by contracted physicians, private diagnostic laboratories and clinics.

Regulatory mechanisms introduced include: a) budget ceilings for EOPYY accompanied by a clawback/rebate mechanism for private providers (pharmacies, pharmaceutical companies, diagnostic laboratories and private clinics) so as to keep expenditure within the budget limits;[10] and b) thresholds on physicians' activity (limits in

[8] A tiny number of health insurance funds did not join EOPYY (and EFKA). These include the health insurance funds of the Bank of Greece and the National Bank of Greece.

[9] Recent legislation (Government Gazette 148/A/9-10-2017, accessed on 30.05.2018, at https://www.e-nomothesia.gr/kat-ygeia/proedriko-diatagma-121-2017-fek-148a-9-10-2017.html) sets limits to EOPYY's status as an independent organization, through the establishment of a special department in the Ministry of Health, accountable directly to the Minister of Health and responsible for overseeing a wide spectrum of decisions concerning EOPYY's budget, the terms and conditions under which private practitioners, diagnostic laboratories and private clinics are contracted, and other activities.

[10] A clawback system requires pharmaceutical companies, private diagnostic centers and clinics, if expenditure exceeds the public health budget, to repay to EOPYY the excess. In 2018, the clawback by pharmaceutical companies reached €560 million, which is about 20% higher than in 2017.

the number of referrals for diagnostic tests, compulsory prescribing by active substance, and electronic monitoring).

The introduction of e-governance tools and attempts to make the public procurement system more transparent and efficient are also among the main cost-containment measures. However, in the absence of systematic health needs assessment at different levels (e.g. regional, local), caps on referrals and prescriptions per specialty (and prefecture), in place in the last few years, are drawn in a rather ad hoc way. For instance, according to a recent Ministerial Circular[11] average monthly per capita prescription rates for pathologists range from €34 to €45, while for forensic surgeons, who seldom issue prescriptions, the rate is set at about €55. Equally unfounded on any sound evidence of demographic and morbidity trends is the fluctuation of rates per prefecture/per month. The obvious aim is a further cut in the value of physicians' prescriptions in tandem with the doubling of the generics share from about 20 to 40%.

Co-payments for pharmaceuticals more than doubled, from about 10 to 25% (plus an extra charge of €1 per prescription), and a 15% co-payment for diagnostic and laboratory tests in contracted centers was introduced. Exemptions from co-payments (or lower rates) apply to individuals and families with very low income (including the uninsured with low income) and some vulnerable groups (e.g. people with chronic diseases) on the basis of income criteria.[12] At the same time, existing exemptions from user charges for some groups were lifted. For instance, for the chronically ill persons exemptions are strictly related to their chronic illness, even though some of their ailments maybe an indirect consequence of their health conditions (Petmesidou, 2014: 20).

Other major measures for lowering prices and volumes of pharmaceuticals embrace the establishment of a drug-pricing observatory and a reference pricing system that sets the rates on the basis of the average price of the three lowest-priced markets in the EU; the introduction of a positive (and negative) list for reimbursement purposes; the reduction of the profit margin for pharmacies; and ceilings in physicians' prescriptions, as stressed above.

An entrance fee of €3 for outpatient care, introduced in 2010 (and increased to €5 in 2011), as well as a €5 fee charged for every hospital admission since 2014, were abolished in 2015. But private outpatient clinics, run within public hospitals in the afternoon, charge fees per visit, which, however, are not covered by social insurance. In the last few years, the rising number of visits to afternoon clinics of public hospitals is

[11] Accessed on 15.10.2018, at https://www.taxheaven.gr/laws/circular/view/id/29287.
[12] The income thresholds for exemption or lower rates of co-payments are set at €2400 and €3600 per year, respectively, for a single person (they increase by €600 for each dependent).

the result of long waiting lists for free access to specialists. Also, since 2012, patients who receive treatment in private hospitals/clinics contracted by EOPYY must pay 30% of the total cost.

Informal payments have persistently been a major component of out-of-pocket payments keeping private spending high and exacerbating inequalities in care. They are common for skipping waiting lists and as undeclared cash payments to physicians and surgeons. Comparatively low salaries of ESY health personnel in Greece vis-à-vis other EU countries, further reduced during the crisis, partly account for this behaviour. Strikingly, a rough estimate by Liaropoulos (2010) sets the size of the black economy in the health sector (defined as the aggregate of "graft, fraud and under-the-table payments" in the public and private sector) at about €4 to €5 billion annually, during the decade of the 2000s. This should total approximately €50 billion in the end of the decade, an astonishing amount that is equal to the cumulative public deficit from 2003 to 2009 (*ibidem*). Even though this estimate should be taken with caution, it provides a glaring indication of the serious inefficiencies of the healthcare system. Nevertheless, it is worth noting that, despite measures for combating systemic problems, and the strains on household incomes during the crisis, the practice of under-the-table payments continues unabated. A survey conducted in 2012 "reports under-the-table payments for approximately 32.4% of public hospital admissions" (Souliotis *et al*., 2016: 159), and an equally high percentage (36%) of undeclared fees paid for visits to private practitioners and dentists (*ibidem*; see also Liaropoulos *et al*., 2008).

In a nutshell, considerable improvements in rationalizing funding accrue to the pooling of resources, the establishment of a single payer, the shift from retrospective reimbursement for secondary health service provision (based on the patient cost per specialty) to a case-mix payment, and a raft of strict monitoring policies for doctors. Yet, policy wise, a systematic allocation of resources across the country on the basis of need, drawing upon demographic, socio-economic and epidemiological data has hardly been in place. YPEs could potentially play a crucial role in developing needs assessment mechanisms, provided their budgetary and planning competences are strengthened. A Health and Welfare Map to monitor health needs, allocation and use of resources that could feed into policy decision-making has been on the agenda of the Ministry of Health since the early 2000s, but with very little progress so far.

3.3. Institutional/Organizational Arrangements in Service Provision

Organizational reform embraces: a) a two-way trend of centralization/decentralization of administrative and governance functions and controls, and b) a consolidation of secondary care providers into larger units.

3.3.1. A Two-Directional Trend

The split trend along the first dimension consists, on the one hand, in: the pooling of financial resources through the establishment of EOPYY (and, later on, of EFKA); the centralization of decision-making and control over the range of service provision and resource allocation methods; and the ongoing trend of centralized procurement of medical supplies and devices so as to reduce less-than-optimal outcomes and improve transparency. Also, new information systems – such as electronic platforms for collecting/monitoring data on performance – accompany centralization policies of governance. Though, so far, these do not embrace any quality indicators and quality assurance strategies.

On the other hand, legislation for primary care enacted in 2014 transferred responsibility for primary care coordination to regional health authorities. The law provided for the redrawing of the primary care map by creating a mixed-system of providers embracing the about 200 hundred rural surgeries (transferred from ESY to PEDY), the urban primary healthcare units (ex-IKA units transferred to EOPYY in 2012, and to PEDY in 2014), and contracted physicians and private laboratories. However, the networking plan was hardly implemented. A significant reduction of the medical staff in the ex-EOPYY health centers considerably limited public service provision. The reduction in staffing levels was caused by the change in the employment conditions for medical doctors under PEDY. Physicians employed in the ex-EOPYY units were asked to choose whether to become full-time employees in the National Primary Healthcare Network and close down their private practice, or else terminate their participation in the system. Medical doctors of ex-EOPYY health units strongly opposed the reform bill, demanding that full-time work conditions be in force only for new appointments in PEDY, while those who served under IKA and EOPYY for over 15 years be allowed the option of combining private practice with provision of services in PEDY units until they retire. Eventually the reform bill turned into law, as this was a policy stipulated by the bailout package, and a significant number of physicians of urban health centers chose not to join the new organization.

In 2017, new legislation passed by the coalition government between SYRIZA (Coalition of Radical Left) and ANEL (Independent Greeks, a small, far-right populist party) added a further layer of primary services, the so-called Local Units of Primary Care (TOMYs, in the Greek acronym), planned to operate as gate-keepers to the system and strengthen primary prevention and health promotion activities. Under the new plan, PEDY units will function as a second-tier ambulatory care. TOMYs, together with contracted private physicians (general practitioners, pathologists and pediatricians) will establish a local gate-keeping network, targeting family doctor

services for all. Once more, an attempt is made to integrate primary care into the public system and counteract overreliance on specialist and inpatient care. However, the implementation of the plan is beset with problems. The time-span of budgetary provision for the operation of TOMYs is limited (up to four years maximum) and funding is tied to EU sources. Besides, adequate infrastructure is hardly available in many localities. Similarly, to other services relying on EU sources (e.g. the Home Help program), there is the risk of service discontinuity when EU funding stops. These uncertainties account for the low response by doctors (even junior ones facing unemployment) to repeated calls by the Ministry of Health for filling positions in TOMYs.[13] Equally difficult has been so far to attract private practitioners to the local primary care network, to be contracted family doctors. Significant changes in EOPYY's contract conditions (lower earnings for higher workload and restrictions on private practice) met with the reluctance of private practitioners to join the planned primary healthcare network. As stressed in a recent report (EC, 2018c: 36), "slow progress may increase the risk of future discontinuation or reversal".

3.3.2. Consolidation of Secondary Care Providers

Re-configuration of secondary healthcare service providers has been on the way during the last few years with the aim to contain cost and rationalize structure and governance. Policy measures embrace the redrawing of the hospitals map, by combining them into fewer units under common administration, the cutting down and/or rearrangement of clinics and functional beds, changes in the function of several ESY healthcare facilities, staff relocation and redistribution of heavy equipment across hospitals. However, so far, these policies have limited implementation, and according to a recent study their positive effect on overall hospital efficiency has not been significant (Kaitelidou *et al*., 2016). Efficiency improvement is also sought by measures such as the introduction of a double-entry accounting system for costing services, the all-day functioning of hospitals, extension of working hours of outpatient offices, and the revision of emergency and on-call duty.

Notably, staff shortages have intensified, due to hiring freeze for several years, and persistent reliance on term-contract appointments of health personnel. Most importantly, the shortage of nursing staff seriously affects service delivery – in some of the main hospitals in Athens cutbacks have left one nurse to look after 20 or more patients (Petmesidou, 2014: 19). Greece ranks last among the EU28 countries in terms of the ratio of nurses per 1,000 population (3.2 in 2014, EU28 average 8.4). Staff

[13] In late 2018, only about 100 TOMYs (from a planned total of 240 units) started operating.

shortages also affect intensive care units, some of them operating below their capacity (Economou *et al*., 2017: 78). According to WHO standards, 9 to 12% of functional hospital beds must be in intensive care units. In Greece, the rate is close to 2%, while over a fifth of them are not in operation due to qualified staff shortages.[14] Overall, major challenges remain with regard to the deployment and management of resources, coordination with primary care, response to need, and quality of services.

4. Inequalities of Healthcare: Accessibility and Affordability

Austerity-driven cuts and reforms cast doubts on the "universal" character of the system. Equalization of provision across social insurance funds was accompanied by a significant review of the range of public provision, leading towards a low common denominator. This shifted provision to the private sector and, in tandem with significant inequalities in the geographical distribution of public health facilities, greatly impacted upon accessibility to and affordability of healthcare.

Importantly, the crisis conditions brought to the fore the serious problem of a rapidly increasing number of uninsured people. In 2013, it was estimated by EOPYY (Petmesidou *et al*., 2014: 345) that there were about 2.5 million people lacking healthcare coverage. These included the long-term unemployed and their dependents, people who filed business bankruptcy, or who might still run a business but were unable to pay contributions due to severe hardship, and legal/illegal immigrants and refugees. In 2013, a program was launched providing (on a means-tested basis) vouchers that allowed uninsured persons and their dependents to have access to primary and ambulatory care. However, eligibility and range of ambulatory provisions were limited, inpatient care was not covered, and the scheme fell short of covering need. In 2016, new legislation lifted most barriers for uninsured citizens in accessing outpatient and inpatient publicly provided care. Nevertheless, as the uninsured are barred from contacting private providers contracted by EOPYY, inequity of access persists, especially in regions/localities with staff shortages and lack of diagnostic equipment in public health facilities.

Increased co-payments and fees as well as long waiting lists also function as rationing measures creating barriers to access. In certain prefectures, the quicker appointment one can get for seeing a pathologist or a cardiologist in EOPYY could be in two or more weeks, while in the national hospitals network it might take even longer (Petmesidou, 2014: 23). Particularly long are waiting times for heart surgery: on

[14] Data from a research carried out by the Panhellenic Federation of Public Hospital Employees (POEDHN). Accessed on 05.10.2018, at https://www.poedhn.gr/deltia-typoy/item/2939-megali-erevna-tis-poedin-gia-tis-monades-entatikis-therapeias-se-74-nosokomeia.

average, two to four months across the country, but in certain cases waiting may reach or surpass six months (Boulountza, 2016). A ministerial decision issued in late 2016 made obligatory a more transparent use of priority medical criteria for waiting lists. Public hospitals have started complying with this measure, but it is too early to assess its effectiveness. Discontinuity in the procurement of vital medical supplies in ESY hospitals and PEDY health centers is another blockage mechanism.

Household expenditure data of the lowest income quintile show that, in the beginning of the crisis, average equivalized monthly health spending was a little over 10% of total consumption expenditure.[15] It sharply dropped to about 7% in 2012, but increased afterwards reaching again a ratio close to 10% in 2016 (with a slight decrease in 2017), even though total household expenditure persistently followed a downward trend from 2009 onwards. With regard to the constitution of average monthly spending on healthcare by households in the lowest income bracket (up to €750 monthly), a striking 60% concerns pharmaceuticals (and medical devices), about 25% payments to physicians, and the rest mostly inpatient care in private hospitals and clinics.

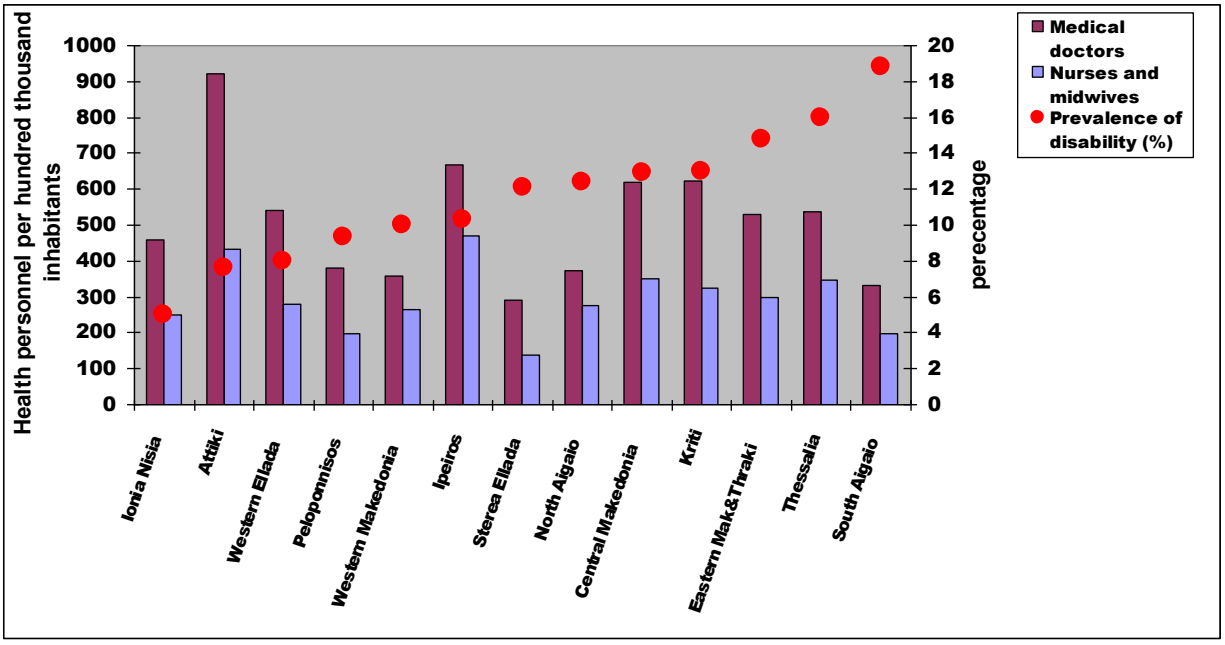
As healthcare demands are inelastic, significant cuts in public provision made necessary even among poorer households to spend a growing part of their monthly income in order to cover healthcare needs. In the available literature, a threshold of 10 to 15% (or over) of household monthly income (or consumption) spent on out-of-pocket healthcare payments is considered to be a “catastrophic” and “impoverishing” cost for households (see Xu *et al*., 2007). A case study conducted by Grigorakis *et al*. (2017) on the basis of a sample of people covered by mandatory social insurance, who “were hospitalized at least once in private providers contracted by EOPYY”, highlights the high risk of “catastrophic health costs”. About a third of their respondents declared having incurred a cost amounting to over 30% of their monthly income for health treatment (for the poverty impact of out-of-pocket payments see also Petmesidou *et al*., 2015: 253-268; Chantzaras and Yfantopoulos, 2018). Other case studies (see Tsiligiani *et al*., 2013 and 2014; Petmesidou *et al*., 2015: 295-342) also show that a substantial number of people discontinue medication or lower their doses, as they cannot afford the cost, with perilous effects on their health though.

The geographical distribution of health facilities and personnel is a major dimension of unequal access. Among EU countries, Greece exhibits a high ratio of practicing physicians per 1,000 population (6.3, almost double the ratio EU28, in 2015), the vast majority of whom are specialists. There are very few general practitioners, and

[15] ELSTAT data accessed on 15.10.2018, at http://www.statistics.gr/el/statistics/-/publication/SFA05/-.

shortage of nursing staff is a persistently serious problem, as indicated earlier. Figure III shows the high concentration of health personnel in the two regions with the largest urban centers (Attica and Central Macedonia), as well as in two regions with well-established medical schools (Epirus and Kriti). It also depicts the prevalence of disability (and chronic diseases) by region (latest available data from an ad hoc study of disability carried out by ELSTAT in the early 2000s). Strikingly, the regions with the highest rates in the prevalence of disability score lowest in terms of health personnel per hundred thousand inhabitants. Inequalities in the spatial distribution of health facilities are compounded by the problem of physicians' brain-drain since the eruption of the crisis (see Ifanti *et al*., 2014). According to the most recent available data, until mid-2018 about 12,700 physicians (mostly specialists) left the country.[16]

FIGURE III – Regional Distribution of Health Personnel (2016) and Prevalence of Disability



Source: Eurostat data on health personnel by region and ELSTAT ad hoc study on disability (2002). Accessed on 20.11.2018, at https://ec.europa.eu/eurostat/data/database and http://www.statistics.gr/en/statistics/-/publication/SJO12/- respectively.

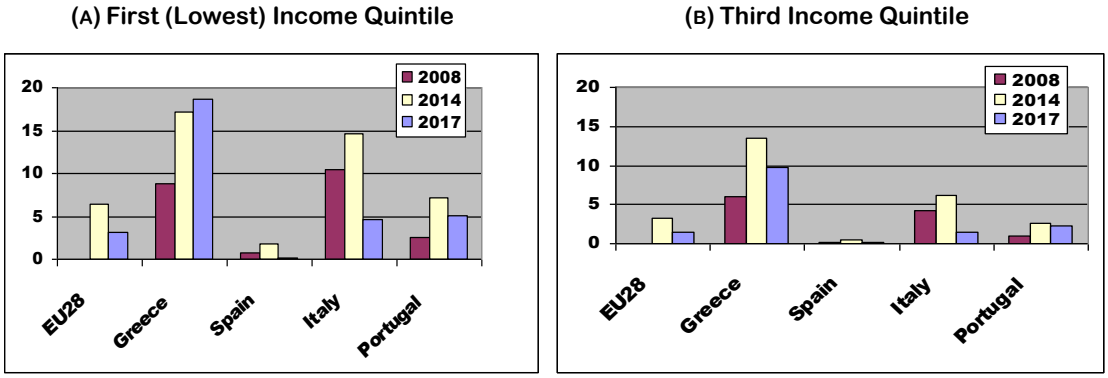
Barriers to accessing public health services in a time of crisis and inability to get medical treatment in the private sector (because this is unaffordable for people in economic hardship) seriously increase unmet need for medical care. This is reflected in the increasing use of free access clinics run by Non-Governmental Organizations – NGOs (e.g. Médecins du Monde). Until the late 2000s, people turning to NGOs were mostly immigrants. Only about 4% of Greeks sought "street medical care". Yet, amidst

[16] Data obtained from the Athens Medical Association.

the crisis, estimates indicate that about a third of the Greek population turn to such clinics or seek support for covering their healthcare bills (Petmesidou, 2014: 24; see also Petmesidou *et al*., 2015: 269-293; Adam and Teloni, 2015).

In the lowest income quintile unmet needs for medical examination have steadily increased from 2008 onwards (Figure IV). In 2017 close to a fifth of this income group declared unmet needs. A significant increase characterized also middle-income groups (3rd income quintile). The respective rate for this income group equaled 12% in 2014, and slightly declined to 10% in 2017.[17] Compared to the other three South European countries (and to the EU28 average) unmet needs have been most prevalent in Greece until recently. It is noteworthy also that, in the last few years, the intensification of refugee (and immigrant) flows in the country (mainly from the Middle East and Africa) further ratcheted up the pressure on public and voluntary health services.

FIGURE IV – Self-reported Unmet Needs for Medical Examination ("too expensive, too far to travel or long waiting list")



Source: Eurostat data accessed on 10.11.2018, at http://ec.europa.eu/eurostat/data/database.

Although life expectancy at birth steadily increased over the last decades (81.5 years in 2016, EU28 average 81.0 years), healthy life years at birth have been falling since 2007. Accelerating demographic ageing is a significant factor affecting this decline. Yet, at the same time, there is evidence that austerity measures have significantly impacted upon the decrement in the populations' health. According to the Global Burden of Disease Study (2016: e404), "from 2010 to 2016, Greece was faced with a five-times greater rate of annual all-cause mortality increase and a more modest increase in non-fatal health loss compared with pre-austerity". Specifically, we observe "a rise in communicable, maternal, neonatal, and nutritional diseases since 2010"

[17] A study by Zavras *et al*. (2016: 5), referring to the early years of the crisis, found that, for the total population, "the odds of unmet needs due to financial reasons were 44% higher in 2011 as compared with 2006".

(*ibidem*; see also Laliotis *et al*., 2016). Undoubtedly, it is rather difficult to disaggregate potential root cause factors of these outcomes (i.e. demographic profile, long-standing system specific characteristics, and the effects of austerity measures). Nevertheless, the fact that the worsening of public health takes place in tandem with a sharp reduction in public health spending and provision, makes it highly likely for the latter to have played a major role in the deterioration of the population's health conditions.

5. CONCLUSION

For a long-time health insurance and healthcare in Greece followed a splintered pattern. In the early 1980s, on a highly fragmented health insurance system, a layer of universalist healthcare was introduced. However, inequalities in the scope and coverage among socio-occupational groups persisted, and the path breaking reform of the introduction of ESY hardly managed to become a driver of wholesale change towards a fully developed national health system. Instead a "disjointed" configuration prevailed. This combined limited application of the principle of universal access with fragmented and unequal health insurance, in tandem with rapidly rising private, out-of-pocket payments. The statist-clientelist mode of socio-political integration that characterized the country for many decades accounts for the consolidation of strong "veto" points resisting change. Subsequent reform attempts in the decades of the 1990s and the 2000s made little progress in tackling inherent system inequities and financing/organizational deficiencies.

The crisis provided a window of opportunity for promoting system integration, as envisaged by the 1981 reform, yet under conditions of sharply declining public spending and a leaner basket of provisions. A number of factors have facilitated reform. Fiscal surveillance by and increasing influence of supranational actors shifted decision-making upwards to the international lenders and the national executive branch, while traditional veto players, such as major trade unions and privileged health insurance funds, were sidelined. At the same time convergent policy options among EU countries guided reform towards: a) strict cost-containment and control measures shifting the cost to patients, and b) a two-pronged approach to governance consolidating service providers but also decentralizing administration and management.

Undoubtedly, reforms increased system rationalization but blunt ceilings set by the bailout package drastically compressed the scope, quantity and quality of services. Seemingly, unification and standardization of health insurance aimed to tackle inequalities in coverage and access. But shrinking public provision runs counter to this. Unmet need for medical care greatly increased among lower-income groups (with a

noticeable rise also among middle-income groups) and inequalities in terms of accessibility to and affordability of services deepened. Mandatory, state-regulated complementary insurance through the market is absent and the risk of catastrophic out-of-pocket payments appears to be high, particularly so, as "reforms increasingly co-opted universal public healthcare into private operators" (Petmesidou, forthcoming). Greece's post-bailout commitments stipulating strict fiscal targets for the years ahead, in order for the country to service its huge public debt, leave little room for any policy options, in the near future, which could reverse course and harness the potential of reform for enlarging the scope and improving quality of universal healthcare.

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